STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 19, 2022

Christopher Schott
The Westland House
36000 Campus Drive
Westland, MI 48185

RE: License #: AH820409556
Investigation #: 2022A1027092
The Westland House

Dear Mr. Schott:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2022A1027092
Complaint Receipt Date:	09/07/2022
Investigation Initiation Date:	09/09/2022
Report Due Date:	11/07/2022
Licensee Name:	WestlandOPS, LLC
Licensee Address:	2nd Floor 600 Stonehenge Pkwy Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Administrator:	Wanda Kreklau
Authorized Representative:	Christopher Schott
Name of Facility:	The Westland House
Facility Address:	36000 Campus Drive Westland, MI 48185
Facility Telephone #:	(734) 326-6537
Original Issuance Date:	02/25/2022
License Status:	REGULAR
Effective Date:	08/11/2022
Expiration Date:	08/10/2023
Capacity:	102
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive medications as prescribed.	Yes
Additional Findings	No

III. METHODOLOGY

09/07/2022	Special Investigation Intake 2022A1027092
09/09/2022	Special Investigation Initiated - Telephone Telephone interview conducted with complainant
10/12/2022	Inspection Completed On-site Interviews and documentation received on-site. Requested follow up email with medication policy.
10/13/2022	Contact - Document Received Email received from Ms. Kreklau with medication policy
10/17/2022	Contact - Telephone call made Telephone interview conducted with Employee #2
10/19/2022	Inspection Completed-BCAL Sub. Compliance
11/18/2022	Exit Conference Conducted with authorized representative Christopher Schott by voicemail.

ALLEGATION:

Resident A did not receive medications as prescribed.

INVESTIGATION:

On 9/7/2022, the department received a complaint through the online complaint system dated 8/21/2022 which read Resident A's prescriptions were filled by the Veteran's Administration (VA), then delivered to the facility for staff to provide to Resident A. The complaint read Resident A's family was not notified in a timely manner by facility staff that Resident A had run out of her medications. The

complaint read after the notification; Resident A's family member visited the facility in which she was informed by Employee #2 that not all her medications were in the medication cart. The complaint read Employee #4 informed the family member that Resident A had received all her medications and some of the medications were locked in Employee #1's office. The complaint read Employee #1 was the only staff member with the key in which she would access the medications on Monday. Additionally, the complaint read Resident A's family was informed by a nighttime staff member that she had not received two of her nighttime medications.

On 9/9/2022, I conducted a telephone interview with the complainant whose statements were consistent with the complaint. The complainant stated there was concern Resident A had not received all her medications since the facility staff stated they were out on 8/20/2022. The complainant stated Resident A's family was notified by facility staff that her medications were delivered and located in a cupboard at the facility, however there was still concern she had not received them as prescribed since they were not located in the medication cart.

On 10/12/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated she had transitioned to her role in August 2022. Employee #1 stated at that time, Relative A1 and her reviewed all Resident A's medications together to ensure there was sufficient supply. Employee #1 stated there was a heart medication that required a physician's signature which was completed. Employee #1 stated Resident A utilized the physician Dr. Elemenini who visited the facility. Employee #1 stated Resident A received her medications from the VA in which the facility physician would write a prescription, then was given to Relative A1 to be sent to the VA pharmacy. Employee #1 stated Resident A's medications were delivered to the facility from the VA and placed on the medication cart if needed at that time, otherwise they were locked in a cabinet in her office. Employee #1 stated her office was always open. Employee #1 stated staff obtained the cupboard key from the top drawer of the desk in her office to unlock the cupboard which maintained all resident's extra supply of medications. Employee #1 stated the process to ensure Resident A's medications were available for administration was for staff to inform her by telephone when the medication supply was low, then she informed Relative A1 by text message so family could contact the VA pharmacy for a refill. Employee #1 stated staff were trained regarding where to obtain resident's refill or extra supply of medications from her office. Employee #1 stated Employee #4 no longer worked for the facility.

While on-site, I reviewed Resident A's medical record in which there was a hand-written letter in which was not dated nor signed by anyone. The letter requested a review of Resident A's medication list because she had bottles of the following medications: Isosorbide, Cholecalciferol, and Cyanocobalamin. The letter read requested written prescriptions for lab work for a UTI, patches for both shoulders, two Tylenol extra strength for morning and night, topical pain cream for her knees and Imodium. Resident A's medical record also maintained prescriptions signed by

Dr. Elemenini and dated 8/25/2022 for medications Imdur, Tylenol, Lidocaine patches, Voltaren gel, and Imodium as well as the lab work.

While on-site, Employee #1 and I reviewed Resident A’s October 2022 medication list in which read consistent with the medications maintained within medication cart. Additionally, Resident A’s medication bottles were observed to have sufficient supply of pills in each, as well as sufficient supply of lidocaine patches.

While on-site, Employee #1 and I observed Resident A’s medications maintained within the locked cupboard. I observed Employee #1 retrieve the key from the top drawer of her desk to open the cupboard. I observed there was additional supply of the following medications: Allopurinol, Duloxetine, Isosorbide, and Vitamin D. Additionally, I observed two bottles of Acetaminophen and two boxes of Lidoderm patches.

On 10/17/2022, I conducted telephone interview with Employee #2 who stated she was still training in August 2022 and recalled that Employee #1 obtained Resident A’s medications from her office.

I reviewed Resident A’s face sheet which read she had admitted to the facility on 2/11/2022. The face sheet read Relative A2 was her durable power of attorney (DPOA) and was responsible for her bills.

I reviewed Resident A’s service plan dated 8/19/2022 which read staff administered her medications.

I reviewed Resident A’s medication administration records (MAR) dated August 2022 which read the following dates were left blank for one or more doses of the following medications: Atorvastatin 8/30/2022 and 8/31/2022, Diclofenac gel 8/5/2022 through 8/8/2022, 8/30/2022 and 8/31/2022, Glimepiride 8/30/2022 and 8/31/2022, Lantus 8/30/2022 and 8/31/2022, Lidocaine pad 8/30/2022 and 8/31/2022.

I reviewed the facility’s medication administration policy which read in part

If a medication is not administered, the staff member responsible for administering the medication shall document in the resident’s record why the medication was not administered.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Staff attestations and review of facility documentation revealed staff were responsible for Resident A's medication administration. Review of Resident A's MARs revealed there were dates left blank in which it could not be determined if Resident A's medications were administered or not and read inconsistent with the facility's policy. Based on this information, this allegation was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see licensing study report (LSR) dated 8/31/2022, CAP dated 9/23/2022]**

On 11/18/2022, I shared the findings of this report with authorized representative Christopher Schott by voicemail.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend this license remain unchanged.

10/19/2022

Jessica Rogers Date
Licensing Staff

Approved By:

11/17/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section